The Nightingale Clinic

(0845) 833 6553

www.nightingale-clinic.co.uk/colonic

Date of initial consultation: ____________________

Practitioner: ____________________

Colonic Hydrotherapy Health Questionnaire

All information is treated in the strictest of confidence

Please complete clearly in block capitals

Personal details

Name: Mrs / Miss / Ms / Mr / Dr ____________________

Address 1: ____________________

Address 2: ____________________

Town: ____________ County: ____________ Postcode: ________

Tel # Home: ____________ Work: ____________ Mobile: ____________

Email address: ____________________

Occupation: ____________________

Previous occupations: ____________________

Place of birth: ____________________ Date of birth: ____________________

Physical details

Height: ___ ft ___ ins **or** ___ m ___ cm Weight: ____ st ____ lbs **or** ____ kg ____ g

Does your weight vary much? Yes / No

Research

Where did you find out about The Nightingale Clinic? ____________________

Where did you first hear about colonic hydrotherapy? ____________________

What is your primary reason for wanting colonic hydrotherapy? ____________________

1. Medical History

Have you ever had, or do you currently suffer from, any of the following?
(Please tick)

Migraines	Anaemia
Tinnitus	High / low blood pressure
Hay fever	Skin problems e.g. eczema/psoriasis/boils
Asthma	Rheumatism
Bronchitis	Gout
Back problems	Arthritis
Neuralgia	Haemorrhoids
Ulcers	Diabetes
Herpes	Gallstones
Diverticulitis	Stomach problems
Kidney problems	Cystitis
IBS	Colitis
Hernia	Anal fissures

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2. Current health

Do you experience any of the following?
(Please tick)

Flatulence	Heartburn
Indigestion	Nausea
Bloating	Constipation
Diarrhoea	Faeces that seem to be a strong colour
Blood or mucus in your faeces	Faeces with a strong odour
Pain/difficulty having a bowel movement	Other digestive problems
Mucus or catarrh	Frequent colds
Cold sores	Cracked skin
Sensitive gums	Throat infections
Dizziness or light-headedness	Runny or itchy eyes
Mouth ulcers or gum boils	

How often do you have a bowel movement? ____

How many times do you urinate each day? ____________

3. Stress

Do you have low energy levels? Yes / No

Do you have any sleeping difficulties? Yes / No

If yes, what are they? ______________________________

Do you suffer from any of the following?
(Please tick)

Poor short-term memory	Confused thinking
Over-sensitivity to noise	Overactive thinking

Have you been/are you depressed? Yes / No

4. Medication

Are you on any form of medication? Yes / No

If Yes, please specify:

Name of the medication: ______________________________

How long you've been taking it: ______________________________

Do you take any daily vitamins or nutritional supplements? Yes / No

If Yes, please specify:

Name(s) of vitamins / supplements taken (including dosage if known): ______________________________

____

Have you taken any of the following medications, or any other medication not specified, for an extended period?

Antibiotics	Yes / No	Steroids	Yes / No
Cortisone	Yes / No	Heart drugs	Yes / No
Diuretics	Yes / No	Other (please specify):	______________

If Yes, please say when and what for: ______________________________

5. Family

Marital status (please tick):

Single	Married
Widowed	Separated
Remarried	

Do you have children? Yes / No If yes, please specify gender and ages: ______________________________

Does anyone else live at home with you? Yes / No

If yes, who? ______________________________

6. Food

Please write down what you eat and drink on a typical day, including quantity.

Fresh fruit: ______________________________

Vegetables: ______________________________

Meat: ______________________________

Dairy produce: ______________________________

How much water do you drink? ______________________________

Other drinks: ______________________________

Are you allergic/intolerant to any foods or drinks? Yes / No

If yes, which ones? ______________________________

Do you crave any of the following?
(Please tick)

Sweet things	Salty things
Coffee	Tea
Nicotine	Chocolate
Alcohol	Anything else (please specify): ______________

Are there any foods you find it hard to digest? Yes / No

If yes, what are they? ______________________________

Do you smoke? Yes / No

If yes, how many a day? ______________________________

7. Family history

Have any of your parents, grandparents, brothers or sisters had any health problems? Yes / No

If yes, who and what? ______________________________

____

____

8. Operations

Have you ever had any operations, including any minor operations? Yes / No

If Yes, please state what the operation was for and the age you were at the time:

____

____

____

____

9. Exercise

Write down all the exercise you have taken during the last week. Include all walking to work, frequent running upstairs, dancing, gardening, etc., as well as the more obvious activities such as playing sports, yoga, aerobics, swimming, etc.

____

____

____

10. Health

What aspects of your health would you like to improve?

____

____

____

Women only

Do you currently have, or have you ever had:

Pre-menstrual tension	Yes / No
Any problems with your periods	Yes / No
Menopausal symptoms	Yes / No
Cervical erosion	Yes / No
Pelvic inflammatory disease	Yes / No
Thrush or other vaginal discharge	Yes / No
Are you pregnant?	Yes / No

Men only

Have you ever had:

Thrush	Yes / No
Cystitis	Yes / No
Prostate problems	Yes / No
Vasectomy	Yes / No
Any sexually transmitted disease	Yes / No

(if yes, please specify: ____________________)

11. Consent

"I confirm that the information given above is complete and correct to the best of my knowledge and belief. I also understand that I must inform my therapist of any changes in the above information, or in any other health considerations, before any subsequent treatments."

Signature: ____________________________ Date:____________________________